HEARING ASSOCIATES, INC.
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AUDIOLOGY AND HEARING AID DISPENSING
www.HearingAssociatesNorthridge.com

Notice of Financial and Payment Policy

Welcome!

It is our pleasure to serve the San Fernando Valley Community. Please read the following office policies. If you have any questions please ask a staff member for answers to your needs.

- **Insurance (Participating Providers)**

  We participate with many Insurance Companies including Medicare. We are also a contracted Provider's with Facey Medical Group and HealthCare Partners Medical Group. If you are unsure if we are contracted with your Insurance Company please ask the Front Office before being seen by the Audiologist. If we are not a contracted Provider with your Insurance Company, we may bill you in the future if a Co-Insurance or Deductible was applied to your policy.

- **Payment/Co-Payments**

  Payment for any Hearing Aid(s) services are due at the time of services unless other arrangements are made. If you are out of Warranty Services on your Hearing Aid(s) or you did not purchase your Hearing Aid(s) you may be responsible to pay for In House Services.

- **Returned/Stopped/Bounced Checks**

  There will be a $35.00 charge and the original balance due will also be applied.

- **Penalties & Office Billing Fees**

  Once your Insurance companies have settled your claim, you may receive a bill for any balance, which is considered "Patient Responsibility". This may include deductibles, co-payments, co-insurances not paid at the time of service. Please pay your bill promptly. If not paid within 90 days it will be forwarded to a Collection Company. If you need to make any payment arrangements please do it with the Office Manager.

- **Missed Appointment & Same Day Cancellation Fee**

  Our office will charge a fee of $25.00-$100.00 for any patient that does not call 24 hrs prior to their appointment to cancel, re-schedule or they miss their appointment. The fee will be based on the type of appointment that was scheduled.

If you have medical insurance, we are pleased to help you receive your maximum allowance benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to you insurance carrier annually.

_____	_____	_____
Patient/Guardian Printed Name	Patient/ Guardian Signature	Date